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AUTHOR	Levy, Susan
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ABSTRACT

State governments, school systems, and local communities are increasingly aware that social problems must be addressed in the context of education reform since many of these problems limit students' ability to learn. Unchecked, these problems have a high social and financial cost in that they prevent young people from becoming self-sufficient adults. One of the problems which is being addressed in many areas of the South is teen pregnancy. Many schools are establishing on-site clinics as part of the solution to the rise in the birthrate among 15-19 year olds. This paper presents models of these clinics as one approach to the complex problems of teenage parenting and pregnancy. These clinics attend to the health needs of pregnant teenagers in comprehensive ways that are more affordable, accessible, and appropriate than traditional health care facilities. Most of these clinics are free, but a few charge a small fee. All require parental permission. School-based clinics from four Southern states are described. (VM)

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INVESTING IN THE HEALTH OF AT-RISK YOUTH
SCHOOL-BASED HEALTH CLINICS IN THE SOUTH

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MODEL PROGRAMS FOR SOUTHERN ECONOMIC DEVELOPMENT

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INVESTING IN THE HEALTH OF AT-RISK YOUTH
SCHOOL-BASED HEALTH CLINICS IN THE SOUTH

"The best way to buy shares of the future with guaranteed profit is to invest in the interdependent lives of Southerners. . . ."

Halfway Home and a Long Way to Go
The Report of The 1986 Commission on the Future of the South

INTRODUCTION

Poverty, poor health, high school dropout rates, young people with limited options and limited visions, drug and alcohol abuse, and teenage pregnancy are some of the obstacles blocking the South's progress toward full participation in a globally competitive economy. Under one of its' ten regional objectives, Strengthen Society as a Whole by Strengthening At-Risk Families, the 1986 Commission on the Future of the South warns southern policymakers that "if investing in schools from first to last is to pay off in economic development, the South cannot ignore those interdependent social problems which poison life and drag the whole system down."

State governments, school systems, and local communities are increasingly aware that social problems must be addressed in the context of education reform because these problems interfere with students' ability to learn. Ultimately, they drain the local and state coffers of limited financial resources for which education reform efforts must compete. Getting at the root of the problems which propel young people towards academic failure and prevent them from becoming self-sufficient adults is a long-term undertaking requiring patient investment.

This paper was prepared by Susan Levy, Staff Associate for Research and Programs. Additional copies are available from SGPB for $2.00 each.

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Although returns may not be immediate, investments in the future of today's youth will mean the difference between a workforce prepared to meet the challenges of a global economy and one which will hold back the whole region with its low level of skills and income.

In the South, where a higher proportion of young people grow up in poor families or in rural areas with relatively fewer physicians and other health care providers, the only medical attention many adolescents receive is emergency treatment for acute illnesses or accidents. What they lack is basic, preventive health care which could detect and correct vision and hearing impairments, inadequate nutrition, dental problems, mental health problems including alcohol and drug abuse, and other undiagnosed and untreated conditions such as anemia or high blood pressure. All of these factors interfere with school attendance and learning capabilities.

Adolescent pregnancy and parenting is one of the most critical health problems facing policymakers and educators at the state and local levels. In a report issued by the South Carolina Department of Health and Environmental Control, Teenage Pregnancy in South Carolina, teen pregnancy is accurately characterized as "Everybody's Problem." Estimates of the public sector costs of first live births to teens under 20 in 1981 in that state were $13,147,000 or $5,350 per teen mother and her first baby. These estimates include medical and welfare benefits for the first year.[1]

The complexity of the problem of teen pregnancy is evident to those who work with at-risk youth. In testimony before the Human Resource Development Committee of the 1986 Commission on the Future of the South, Sharon Lovick, Director of the Support Center for School Based Clinics in Houston, said:

> The effectiveness of any effort to prevent teen pregnancy must be directed at improving or enhancing the quality of life of all young children, both younger and older adolescents, and particularly those now living in poverty. The so-called problem of teenage pregnancy in the United States is but one symptom of how we adults treat our children. Other symptoms include drug and alcohol abuse, school dropouts, school failure, and delinquency.

In the southern states, where teen pregnancy rates are higher than in the rest of the United States (which has the third highest adolescent pregnancy rate in the developed world), there are a growing number of programs and approaches being tried in local communities to decrease the incidence of pregnancy and/or meet the needs of teens who have already become parents. Some are preventive in nature, focusing on family life education in the classroom. The curriculum typically includes lessons in communication skills, responsible decision making, and developing self-esteem in addition to topics on health and reproduction. Other efforts provide counseling and support through adult companions who provide positive role models for youth at risk of becoming pregnant. School-based health clinics, which will be highlighted in this issue of Foresight, provide comprehensive health services to students at locations in or near the school site. These clinics combine preventive

measures, such as family planning education and counseling with prenatal services and postnatal followup for the pregnant and parenting teen, in addition to other basic health services.

The 1986 Commission on the Future of the South recommended that southern policymakers support school-based health clinics. The Commission was impressed with the success they have had in lowering birthrates among adolescent girls and in providing accessible, basic health care to students who otherwise might have gone without. The Commission also found school-based clinics worthy of replication because they integrate the services of multiple agencies, bringing together social workers, nutritionists, educators, counselors, court officers, and medical personnel to treat all of a student's needs. School-based health clinics promote the Commission's philosophy of investing in the early treatment of social ills before "unsolved social problems turn into sinkholes for public funds."

Some of the model programs described in this Foresight are just getting started; others have been in operation for several years. All faced some initial opposition; however, these programs have been able to build strong community support because they have grown out of grassroots efforts by educators, health professionals, and community leaders. Adolescent pregnancy and inadequate access to basic health care are perceived as detrimental to the education, development and self-sufficiency of their adolescent populations. While only a piece of the solution to the complex problems which surround teenage parenting and pregnancy, the success of school-based health clinics thus far in improving the health and welfare of young people warrants the attention of communities throughout the South and the support of state policymakers.

TEENAGE PREGNANCY AND PARENTHOOD IN THE SOUTH

The goal of school-based health clinics is broader than the reduction of adolescent pregnancy and birthrates. Yet because teenage births, especially to single mothers, have reached such epidemic rates in some communities and are associated with such high public costs, their prevention is often the galvanizing issue behind the establishment of school-based health clinics.

The statistics on teenage pregnancy and parenthood paint a disturbing picture in the South. Each year, one out of 10, or about one million teenage girls, becomes pregnant in the U. S. In 1983, 13.7 percent of all births were to mothers under 20. For all but one southern state that percentage was even higher (see Table 1). Although the teenage birthrate has declined in recent years in most states, North Carolina, Oklahoma, and Florida had increased birth rates among 15-19 year olds between 1978 and 1983. Further, the birthrate for unmarried teens has been rising throughout the nation. By 1983, more than 50 percent of births to teens were out-of-wedlock. This increases the likelihood that the family would be poor, since babies born to single mothers are 2.5 times more likely to be poor than those born to two-parent families.[2]

Table 1: Percentage of Births to Women Under Age 20, 1983

RANK IN REGION	STATE	PERCENT	RANK IN NATION
1	MISSISSIPPI	21.5	1
2	ARKANSAS	20.9	2
3	ALABAMA	19.1	3
4	KENTUCKY	18.9	4
5	LOUISIANNA	18.4	6
6	GEORGIA	18.1	8
7	TENNESSEE	18.1	9
8	SOUTH CAROLINA	18.1	10
9	OKLAHOMA	17.6	11
10	NORTH CAROLINA	17.2	13
11	FLORIDA	15.6	16
12	VIRGINIA	13.3	24
13	PUERTO RICO	NA	NA
	NATIONAL AVERAGE	13.7	

Source: "A Profile of the South, 1986-87" Prepared for the Southern Growth Policies Board by Brizius and Foster, 1986.

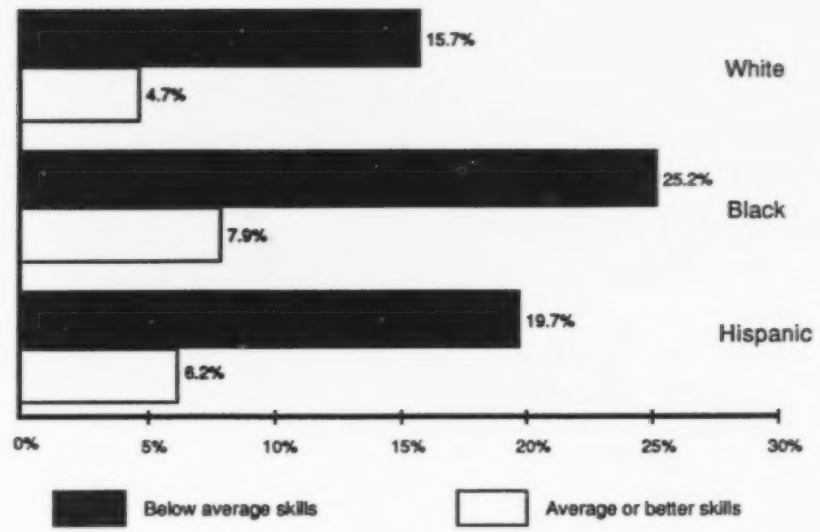
Because public resources are limited, the most effective programs to reduce teen pregnancy and parenthood will be targeted to those young people who are most at-risk of becoming parents. Poverty, limited educational opportunities, low levels of skills acquisition, family instability and lack of parental involvement are intricately linked to teenage parenthood in a relationship where distinctions between cause and effect are often blurred. According to the Children's Defense Fund, one out of five teens from poor families and with less than average reading and math skills are teen parents. Girls with poor basic academic skills are more than three times as likely to become teen mothers as those with average basic skills or better (see Figure 1). The Children's Defense Fund sums up the conditions that influence an adolescent's predilection to become a parent as a "combination of limited opportunities and a less developed sense of their own potential that places poor and minority youths at particularly high risk of early parenthood."[3] If young people are to take the actions necessary to prevent pregnancy, they have to believe that pregnancy would significantly decrease their options for the future.

Intervention to delay pregnancy and parenting among young people must address the complex motivational factors which influence young peoples' decisions about sexual activity and pregnancy. Reducing teen pregnancy is not, therefore, simply a matter of increasing information about family planning or making birth control methods more accessible. While these are necessary components of strategies to lower teenage pregnancy rates, they must be complemented by programs which increase the ability of adolescents to make responsible decisions and which improve their self-esteem and expand their educational and employment

opportunities. Drop-out prevention programs, career planning activities, and teen companion programs for high-risk youth are some of the approaches which have been implemented in conjunction with improved health services for teens.

Figure 1

Parenthood by Basic Skills Levels,
16-19 Year Old Women, 1981



Source: Children's Defense Fund. "Welfare and Teen Pregnancy. What Do We Know?" November 1986. Based on unpublished analyses of the National Longitudinal Survey, Courtesy of Andrew Sum, Northeastern University.

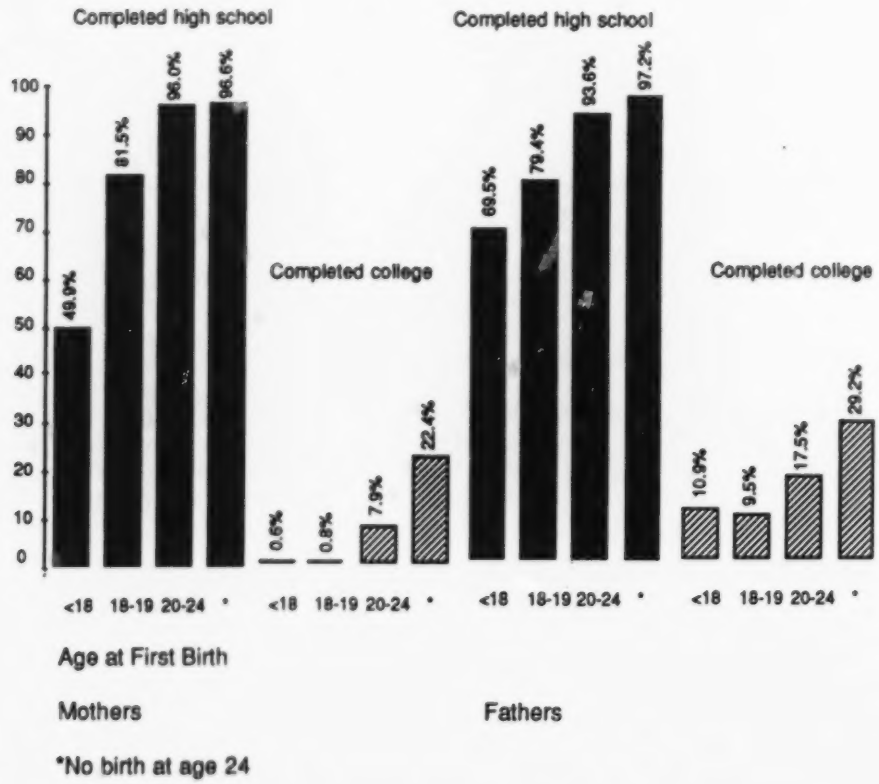
THE HIGH COST OF TEENAGE PARENTHOOD

The costs associated with early parenthood are high to young parents, their children, and the community. Teen mothers, though they are most in need of early prenatal care, are least likely to receive it. This lack of prenatal care means that teen mothers are at higher risk of delivering low-birthweight babies. The incidence of low-birthweight babies was ten percent of all teen births in 1983 according to data from the U.S. House of Representatives' Select Committee on Children and Youth and Families. Low-birthweights often mean expensive postnatal care. The average total cost of a hospital intensive care unit is $10,000-$15,000, and few teen mothers are covered by health insurance or have the resources to pay such a bill. Further, low-birthweight babies have a higher risk of congenital defects and developmental lags, which can also result in high medical costs as well as increased need for special educational and social services. Medicaid, which pays

approximately 30 percent of all hospital deliveries to teen mothers, represents a further depletion of public funds.[4]

Teenage mothers, who are more likely to be single than women who delay childbearing, also have higher dropout rates and lower levels of academic achievement. A national study conducted in the late 1970s used samples of 15 year olds matched by race, socioeconomic status, academic aptitude, achievement, and educational expectations. Upon re-interviewing the same women at age 29, researchers found that 50 percent of those women who had children before age 18 had completed high school versus 82 percent for those who had children at age 18 or 19, and 97 percent for those who waited to have children until they were in their twenties. Less than two percent of teen mothers had received college degrees, versus 25 percent for those women who waited to have children until they were 25 or older (see Figure 2).

Figure 2



*No birth at age 24

Source: "Teenage Pregnancy: The Problem That Hasn't Gone Away." Alan Guttmacher Institute, 1981.

Because of limited education combined with the difficulty many have finding affordable child care, young mothers will have a hard time finding employment, especially at wages that will sustain them above the

poverty level. Teen fathers, the often overlooked other side of teen pregnancy, are unlikely sources of adequate support for their families given the very high rates of unemployment they face (in 1984, the unemployment rate for white males aged 16-19 was 56 percent, for black males, 73 percent). It is not surprising then that young mothers are disproportionately represented among AFDC recipients. According to a 1981 report by the Alan Guttmacher Institute, about one-fourth of teenage mothers were receiving AFDC payments at the time of the report. Two-thirds of families headed by young mothers aged 14-25 live below the federal poverty level, according to the same report.

The children growing up in these poor families headed by teen parents represent another generation of disadvantaged youth. They tend to have lower IQ and achievement scores than children with parents who delayed childbearing, and they are more likely to repeat at least one grade in school.[5] They are also more likely to become teen parents themselves.

The Center for Population Options, a national organization concerned with the prevention of adolescent pregnancy, has estimated the public cost for the one million teenage pregnancies that occur in the nation each year. According to their estimates, in 1985 the U.S. spent $16.65 billion on AFDC, Medicaid, and food stamps for families headed by women who bore their first child while in their teens. Further, the Center found that in 1985 dollars, the cost to the U.S. of all families begun by teen first births in 1985 will be $5.2 billion over the next twenty years. If all teen births had been delayed, they estimated that the U.S. would have saved $2.1 billion, or 40 percent of the full cost (since many women would still require welfare assistance even with delayed births).[6]

SCHOOL-BASED HEALTH CLINICS--ONE APPROACH TO A COMPLEX PROBLEM

While the public schools cannot and should not be expected to shoulder the responsibility for solving thorny social problems, they do, as Sharon Lovick told the 1986 Commission on the Future of the South, "have a compelling interest to see that the health of students is of such quality that they can reasonably expect to profit from the educational program . . . Schools offer an ideal setting to establish positive health habits and to lay the foundation for healthy adulthood."

Adolescents have a wide range of health needs and are especially at risk for certain types of health problems associated with the risk-taking behavior common among that age group. Yet teens are the least likely of all age groups to have a regular source of health care.[7] Affordability and accessibility are major barriers to teens' use of health services. Because adolescents are sensitive to the attitudes of health care providers, they are more likely to use services designed for them and provided by professionals with training in their special needs. For these reasons -- affordability, accessibility, and appropriateness of services -- school-based health clinics are uniquely suited to meet

the health care needs of young people. In rural areas where transportation is a problem and physicians are scarce and in all school districts where the poverty rate is high, these clinics may be the primary, if not only, source of health care for their student populations.

While family planning is an important component of school-based clinics, it is not by any means their sole purpose. In fact, one of the most important features of school-based clinics is that they are comprehensive in the services that they offer. Although the clinics are independent of the school systems, they do develop relationships with administration, counselors, and teaching staff. The clinic staff often teaches the family life curriculum in the classrooms. Clinics are also linked to other services in the community, such as community mental health centers, departments of social services, juvenile court systems, drug and alcohol abuse prevention programs, 4-H Clubs and other youth organizations, and community college programs. By establishing an integrated network of services, school-based clinics can serve as the coordinating body for treating a range of problems that interfere with a student's performance in school.

The economic survival of school-based clinics has thus far been dependent on a patchwork of funding sources, including federal block grant money (Maternal and Child Health, Social Services) and non-block grant Title XX and Title X funds, as well as state and local contributions, including in-kind and private support. A few clinics charge modest fees for their services, but most avoid this practice for fear of discouraging student use. One of the limitations of the school-based clinic model has been the instability of funding. This requires clinic staff and supporters to search each year for sources to provide the money necessary to cover operating costs.

All of the model health clinics described in this issue of Foresight have, as previously noted, achieved acceptance and support in their own communities. All require parental permission for students to take advantage of any of their services, and all make an effort to involve parents, some through parent education programs. Although the staffing patterns are different for each clinic, all have staff devoted to serving the special needs of adolescents and to improving their chances of having a healthy, self-sufficient future.

TEEN LIFE CENTER
DENMARK-OLAR SCHOOL DISTRICT #2
DENMARK, SOUTH CAROLINA

The acronym for the Teen Life Center -- TLC -- is not coincidental. "We didn't want to use the word clinic in our name," according to school nurse Bonnie Harrison, "because it sounds so impersonal." Instead, she hopes that the Center's name and its acronym convey to students and to the community that it is a place which offers an "individualized, caring approach geared to teens and their problems."

Although the Teen Life Center has only been open since the spring of 1986, efforts to reduce the high incidence of teen pregnancy in the Denmark-Olar school district have been ongoing since 1983. The initial impetus to address teen pregnancy and other related problems arose out of teachers' and administrators' concerns about the barriers to motivation and achievement they witnessed in their students. The list of problems -- poverty, poor parental skills, neglect and child abuse, family instability, low readiness levels among the children -- are all too familiar to educators in poor rural areas such as Bamberg County.

Bamberg County, South Carolina, located about 50 miles south of Columbia, is classified by the United States Department of Agriculture (USDA) as a "persistent poverty county." That is, its per capita income ranked in the lowest quintile in the nation in 1949, 1959, 1969, and 1979. Its employment base is a declining agricultural sector supplemented by small, non-durable goods manufacturing plants. Many workers travel outside the county to find work, and unemployment is high (12 percent in 1982). In 1980, only 43 percent of the population twenty-five or older had completed high school and only 9 percent of that same age group had completed college. Bamberg County has a higher proportion of minorities (57 percent compared to 30 percent statewide) and a lower per capita income ($5875 compared to $8039 for the state) than the state as a whole. In 1979, 22 percent of the families in the county had incomes below the federal poverty level, and over a third of children under 18 were living in poverty. The estimated pregnancy rate among girls 14 to 17 years old was 64.1 per thousand in 1982, compared to a statewide rate of 46.3 per thousand in the same year.

The high rate of teen pregnancy in Bamberg County combined with the concern of educators about the impact of students' health and well-being on their ability to learn, led to the introduction of the School/Community Sexual Risk Reduction Program for Teens in the spring of 1983. Administered through the University of South Carolina with funds provided by the Office of Adolescent Family Life Programs, the U.S. Public Health Service, and the Department of Health and Human Services, the program operates by "training as many members of the community as possible to relate effectively to teens and pre-teens the value of postponing sexual activity and using effective contraception in preventing unintended pregnancy." The Program conducts training sessions for four categories of community members: parents, ministers and representatives of the area's churches, students (who will act as peer counselors within the high school), and teachers in the school district.

According to Dr. Murray Vincent, Project Director of the five-year project, the education program has been a "wonderful success." Since the program's inception, there has been both a dramatic drop in the teen pregnancy rate and heightened community awareness about the problem of teen pregnancy. The estimated pregnancy rate in Bamberg County declined from 67.1 per thousand in 1982 to 62.5 in 1983, to 42.3 in 1984, to 36.6 in 1985. Even more telling is the drop in the number of pregnancies among girls 14 to 17 years old in Denmark-Olar School District #2, which serves western Bamberg County and is the site of the project, compared to the control group, Bamberg School District #1, which serves eastern Bamberg County. (The total county population is divided equally between

the two districts.) The number of pregnancies for School District #2 were as follows for the years 1981 to 1985: 18, 22, 20, 8, 8. For the control group, [8]the comparable figures for teen pregnancies were 26, 28, 25, 23, and 18.

Dr. Vincent describes the emergence of the idea to establish a school-based health clinic in the Denmark-Olar School District as a "diffusion process" and an "unanticipated but desirable outcome" of the Risk Reduction Program. Bonnie Harrison, the school nurse and case management coordinator for the Teen Life Center for Denmark-Olar High School, recalled that the idea for a school-based clinic evolved as she and others involved with the Risk Reduction Program found students willing to use human service agencies, including family planning services but unable because of lack of transportation or scheduling problems. Students were also reluctant or unable to figure out the web of services available to them and often needed an advocate to get them through "the system."

With assistance at the state level from the Commissioner of the Department of Social Services, the heads of the various state human services agencies were convened to discuss the concept of a Teen Life Center to be associated with the Denmark-Olar High School. Under the auspices of the State Reorganization Commission's Human Service Integration Project (HSIP), whose members include state-level agency heads, funds were allocated for a Teen Life Center at Denmark-Olar High School, one of eight pilot projects across the state which would "test how a unified human service delivery network could function."

State money ($32,318 in 1986-87) is used to pay the salaries of a part-time project coordinator and clerical staff, purchase office supplies, maintain a computerized recordkeeping system, and pay consultants at the state level who provide assistance in preparing budgets, developing a system of case management, and negotiating with local agencies. The state Department of Health and Environmental Control (DHEC) contributed funds to renovate a facility belonging to the school district, which also pays the salary of the school nurse who staffs the Center.

As a part of the effort to coordinate services and provide case management services to at-risk youth at Denmark-Olar High School, a representative from each county agency visits the Center weekly to provide services or connect students with the services they provide. To ensure continuity, the same person from each agency is sent each week: a drug and alcohol abuse counselor; a mental health counselor who provides group counseling on stress reduction and coping skills as well as a series of counseling sessions for students as an alternative to disciplinary suspension; a nurse practitioner from the health department who provides family planning services; an economic specialist from the Department of Social Services who can accept referrals for services from eligible students; a probation officer from the Department of Youth Services who participates in an "alternatives to suspension" program; a social worker from the Department of Mental Retardation who assists special-needs students in a transition to work program; a nutritionist who conducts a weight control class after school; and participants in

the Department of Social Services-sponsored Teen Companion Project, a program in which teams of peers and adults provide recreational and other field trips for teenagers in AFDC-eligible families.

According to Larry Fernandez, project director for the Human Services Integration Project, the Teen Life Center was chosen as one of the eight pilot projects because it provided an excellent setting for testing the case management model. That model involves assessing an individual's problems, matching those problems with the appropriate services, and tracking progress through the various agencies. Students in this low-income, rural community have multiple problems, and their needs can best be met through coordination of the many services available to them. Fernandez noted that the degree of community support for the project and the commitment from local agencies to participate were also key factors in the decision to fund the Teen Life Center. Because this model involves the local school district as a focal point for services, Fernandez expects the state Education Department to watch this school-based center closely as a potential model to replicate across the state.

The State Reorganization Committee supports the Teen Life Center as one of its model programs under the Human Services Integration Project (HSIP) by offering ongoing technical support. Site visits are conducted every few weeks by HSIP staff, and staff from all of the pilot programs meet every few months to discuss common concerns and trade ideas and approaches that work.

In order to use the services of the Teen Life Center, students must enroll as members. To do so, each student must have parental permission. Staff members of the TLC meet face to face with parents of students who want to join, in the parents' home if necessary, in order to explain to them the full range of services available. When the Center first opened in April and May of 1986, permission slips signed by parents were the only requirement for joining, and 130 slips were returned. Enrollment for the 1986-87 school year has been somewhat slower because of the effort to ensure that parents are aware of the TLC's services. School nurse Bonnie Harrison says that this extra educational effort with parents pays off in terms of easing any apprehensions they might have about their child's participation in the Center. Of the 471 students attending Denmark-Olar High School in grades nine through 12, 50 are now members.

According to Bonnie Harrison, the majority of students who drop into the Center have complaints of illness, health-related questions, or want to talk about their problems. They find at the TLC a supportive environment where the staff and services are focused on teenagers. "What we hope to do at the Teen Life Center," said Ms. Harrison, "is to provide direct services (problem identification, resource finding), and while we're doing that, go a step further and teach these young people that they always have options, that they can control the direction of their lives, and that they have opportunity and responsibility in the choices they make." She added that another of the Center's goals for the future is to increase parental involvement and to build more parent education into the program. "We intend to remain flexible in our

program so that we can respond to the needs of adolescents and their families."

As a pilot project under the Human Services Integration Project, the Teen Life Center will be formally evaluated in the spring of 1987. Educators, human services professionals, legislators, and other policymakers will be watching the progress of this comprehensive, school-based program carefully. It is not only a model for providing health care and reducing pregnancy rates among at-risk youth. It is also a model for coordinating services among the many agencies that serve at-risk youth to improve the efficiency and effectiveness of those services. In its 1986 report, Halfway Home and a Long Way to Go, the Commission on the Future of the South commended this approach to service delivery: "The needs of family members touch and overlap. We can save money while providing easier, more efficient service, by offering the total package in one place, with fewer papers and files and less fragmentation of effort."

For more information, contact:

Bonnie Harrison, R.N.
Teen Life Center
Denmark-Olar High School
P.O. Box 345
Denmark, South Carolina 29042
(803)-793-5001

ADOLESCENT/PARENT PREVENTION PROGRAM
GREENE CENTRAL HIGH SCHOOL
SNOW HILL, NORTH CAROLINA

Students call the blue and white trailer on the grounds of Greene Central High School simply the "Health Trailer." Although the trailer houses a program designed to prevent adolescent pregnancy, the staff also dispenses bandages and other first aid, conducts athletic physicals and diagnostic health screenings, makes referrals to physicians and health clinics, and offers counseling.

The Adolescent Parent Prevention Program (APP) in Snow Hill, North Carolina, is multifaceted, focusing both on family life education in the classroom and coordination of services for at-risk youth. The program serves a student population whose families are on average poorer and less educated than the rest of the state. Greene County, located about 80 miles southeast of Raleigh, is small (population 16,117 in 1980) and predominantly agricultural. In 1979, 19.2 percent of Greene County families had incomes below the poverty level, compared to 11.6 percent for the state. Over one-third of Greene County's children under 18 live in poverty, a rate nearly twice as high as the state's as a whole.

The Adolescent Parent Prevention Program, now in its fifth year of operation, received its initial funding from the federal Adolescent Family Life Program. The Program focuses on serving "adolescent

mothers, expectant parents, and 'at-risk' adolescents in a comprehensive program that includes education (academic, career-oriented, and remedial), counseling and support (linkages to service agencies), health care (prenatal and postnatal services), and nutrition counseling."

The Prevention component of the program focuses on helping preadolescents and adolescents avoid sexual involvement. Individual counseling promoting self-discipline is offered as a follow-up to the Family Life, Postponing Sexual Involvement, and Teen Responsibility curricula, which begin in grade five and continue sequentially through grade 12. Classes are taught by the RN/Counselor and a part-time staff member whose other role within the APP program is as a counselor to the male students.

The other half of the program, the Care component, is offered through the Hookerton Medical Center, a part of Greene County Health Care, Inc., which was established with assistance from the state through the North Carolina Rural Health Care Initiative. Greene County, which has no hospital, had very limited medical services until Greene County Health Care, Inc. was organized the early 1970s, staffed in part by physicians serving with the National Health Corps. Students who need prenatal and postnatal care, family planning services, or other medical attention not offered by Registered Nurse/Counselor Kathy Godwin are referred to the Hookerton Medical Center. The Center charges for its services on a sliding scale. The APP also maintains close ties with and refers students to the county health department, whose services are free.

About 400 students visit the trailer each month for a variety of health-related services. APP Director Helen Hill cites high utilization rate among students as proof that APP is fulfilling a need adolescents have for a program that assures confidentiality and whose staff shows a "caring attitude." "All the knowledge, funds and good intentions in the world will be of little value unless the services offered are acceptable to the population they are intended to serve," commented Ms. Hill.

Like the Teen Life Center, the APP Program coordinates services among a variety of agencies and organizations. "Linkage agreements" have been forged with the Department of Social Services, the county health department, the federally funded WIC program, Green Lamp (the local community action agency), and Lenoir Community College, which offers a GED program and job placement services for pregnant and parenting teens.

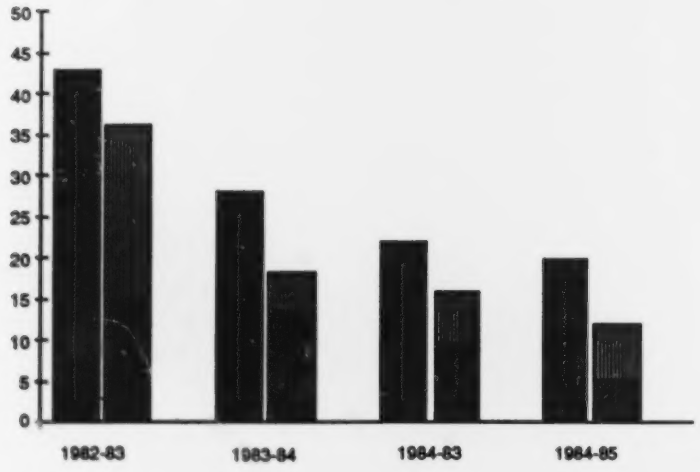
In December of 1985, the APP Director, the Greene County Health Director, and the Wilson/Greene Mental Health Educator joined forces to form the Greene County Triad Project. The objective of this project is to ensure continuity of care for pregnant teens and their children, with particular emphasis on early prenatal care to prevent low birthweights and neonatal deaths. Another feature of the joint effort is a follow-up system, which allows APP's RN/Counselor to immediately contact students who have missed visits for family planning, prenatal or postnatal services. The Triad Project received $24,971 in 1985-86 from the $1.9 million appropriated by the North Carolina State Legislature for 1985-87

to fund community-based adolescent pregnancy and prematurity prevention pilot projects.

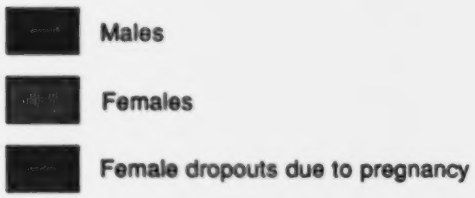
Because of the role pregnancy plays in the dropout rate (in 1983-84, 13 out of the 18 girls who dropped out of Greene Central High School did so due to pregnancy), APP staff also participates in the Greene Central Support Team. It was initiated in 1985-86 by the school administration to reduce the number of students leaving high school early. In 1983, Greene County had the sixth highest drop-out rate in the state. Since then, the number of drop-outs, especially those due to pregnancy, has declined significantly (see Figure 3). The Support Team meets bi-monthly to identify students who are at high risk of dropping out and determine strategies to keep those students in school. For those pregnant students who cannot remain in school, a homebound tutor is provided.

Figure 3

Drop outs in Greene County
1982-1986



Source: Adolescent Pregnancy Prevention Program, 1986.



Since the "health trailer" opened its doors in March of 1983, there has been a heightened awareness in the community about the problem of teen pregnancy. There has also been a drop in the number of teen births in Greene County from 65 in 1983 to 35 in 1985. Ms. Hill cites

these statistics as evidence of the program's impact. She also points to the greater cooperation among the various youth-serving agencies and organizations as a positive outcome of the Adolescent Parent Prevention Program. When federal funding runs out in September of 1987, Ms. Hill hopes that the local school system, the county, and the state will work together to keep this successful program going. "APP has made a significant impact on teen pregnancy," according to Ms. Hill, "but more importantly, we have contributed in providing quality health care to all adolescents in Greene County."

For more information, contact:

Helen Hill, Director
Adolescent Parent Prevention Program
Greene County Health Care, Inc.
P.O. Box 657
Snow Hill, North Carolina 28580
(919)-747-5841

SHANKS HIGH SCHOOL HEALTH CLINIC
QUINCY, FLORIDA

When the Shanks High School Health Clinic opened its doors in January of 1986, 40 of the school's 758 students were pregnant, and according to Gadsden County Public Health's nursing director, Meredith Martin, "woefully unaware of the health issues connected with pregnancy." According to Shank's principal, Carlos Deason, over 75 percent of his students had never had a physical examination.[9] Today, pregnant teens receive prenatal and postnatal care and all students have access to basic preventive health care at this school-based clinic that operates out of a mobile home on the school's campus.

Quincy, Florida is a small town in rural Gadsden County, 20 miles west of Tallahassee. The county's demographic and economic profile is painfully similar to that of many underdeveloped rural counties throughout the South: low levels of educational attainment (only 47 percent of the population 25 and older have a high school diploma); high rates of poverty (43 percent of children under 18 living in poverty in 1979); low per capita income ($5595 in 1980, a little over half the state average); and high teen birthrates (84.6 births per one thousand girls, ages 15-19).

Although the county public health department operates a clinic a few miles from Shanks High School, it was inaccessible to the majority of the student body, three-quarters of whom ride a bus to school, many over long distances. Consequently, school nurse Sylvia Byrd found that prior to opening the school-based clinic, "the kids just weren't getting any medical attention."[10] To alleviate this shortage of basic health care and to tackle one of the highest teen pregnancy rates in the state, nursing director Meredith Martin, school nurse Sylvia Byrd, the school

superintendent, and other school personnel developed a proposal to open a satellite clinic of the county health department on school grounds.

With approval from the school board and a $47,000 grant for start-up costs from Gadsden County's Department of Health and Rehabilitative Services, the clinic opened in early 1986 in its newly-purchased mobile home. A nurse practitioner, a community health nurse, and a clerk -- all full-time employees of the county health department -- and six doctors available three afternoons each week on a rotating basis make up the clinic staff. Through the in-kind participation of other agencies, the clinic is able to offer a variety of related services. A mental health counselor is provided by Appalachi Mental Health, a social worker by Health and Rehabilitative Services, a nutrition specialist by the WIC program, and a childbirth and parental instructor by Project Hope, as a part of the prenatal and postnatal care available to pregnant and parenting students.

Students who use the clinic must first obtain parental permission. By March of 1986, less than two months after the clinic opened, there had been 729 visits to the clinic by the 450 students who received parental permission. According to early statistics, about 15 percent of the visits were for family planning services. The majority of students came for minor physical ailments, athletic physicals, dental screenings, and other routine, preventive care. According to Martin, a number of previously undiagnosed health problems, such as bulemia, drug use, and hypertension, have been detected and treated. "This is the best thing to happen in the county," Martin stated. "These kids need medical care, period . . . and now they are getting it."

As the only school-based health clinic in Florida, the progress of the Shanks High School clinic will be watched by other communities throughout the state who want to improve young people's access to health care and lower their high rates of teen pregnancy. The state legislature, which will consider a proposal to fund school-based clinics on a matching basis with counties, will also be observing this model program in rural Gadsden County.

For more information, contact:

Meredith Martin, Nursing Director
Gadsden County Public Health Unit
P.O. Box 1360
Quincy, Florida 32351
(904)-627-7521

JACKSON-HINDS SCHOOL BASED ADOLESCENT HEALTH PROGRAM JACKSON, MISSISSIPPI

The school-based health clinic which opened at Lanier High School in Jackson, Mississippi, in 1979 was the first of its kind in the South. Founded through the efforts of Dr. Aaron Shirley, a local physician, the

clinic was conceived as a way to reach the many students in this inner-city high school who were unable to afford regular health checkups or follow-up care. The program has since expanded to three other high schools and a junior high school, and has a current operating budget of $194,000.

Each of the five schools served by the health program, Lanier High School, Hinds Agricultural High School, Jim Hill High School, and Rowan Junior High School, have a proportion of low income students that ranges from 68 percent to 89 percent. Over 10 years ago, when local physicians volunteering their services conducted athletic physicals at Lanier, they found many undetected cases of hypertension, urinary tract infections, heart murmurs and other neglected conditions. That the rest of the student body would have similar untreated health problems seemed obvious to these physicians, since so few of these predominately low-income students had a regular source of medical care. Thus the idea for a school-based health clinic in Jackson was born.

Once the clinic became operational at Lanier High School in 1979, the staff identified more than 90 girls out of a student body of 960 who were either pregnant or already had a child. They also discovered that almost a fourth of the pregnancies had occurred while the student was in junior high school. Preventive, educational services were obviously needed at an earlier age, and the following year resources were extended to an inner city junior high school as well as to another high school located in a rural portion of Hinds County. In 1982, the program received funds from the Robert Wood Johnson Foundation to establish clinics at two additional high schools.

The emphasis in the Jackson-Hinds program is on comprehensive services, ranging from medical (including dental) to social and psychological. Each of the five school-based clinics offers a broad range of services and a professional staff of clinical nurses, nurse assistants, pediatricians, and a nurse practitioner. Once a student receives parental permission to participate and becomes officially registered in one of the clinics, he or she undergoes routine lab tests; completes a psychosocial assessment that is designed to determine his or her risk level for drug or substance abuse, violence, suicide, pregnancy, or family conflict; and, depending on the results of the initial screening, is scheduled for an appointment with a physician and/or counselor.

Because of the high incidence of teen pregnancy in Jackson's high schools, the program has developed special counseling efforts geared towards educating students about the significant health and socioeconomic hazards associated with teen pregnancy. Both group and individual counseling sessions are offered. Family planning counseling is provided for those students whose psychosocial assessments determined them to be at risk for pregnancy. Bimonthly follow-ups are done for all family planning students.

For students who are already pregnant, the program arranges appointments for prenatal care through the Main Jackson-Hinds Health Center. The school-based counselor "literally holds the student's hand

straight through the pregnancy," ensuring that she keeps her appointments, watches her diet, follows doctors' instructions, stays in school as long as possible prenatally, and returns as soon as possible after the baby's birth. Daycare is provided for the infants of teen mothers to further facilitate the young mother's return to school, and counseling efforts are continued to reduce the possibility of a second pregnancy. Group sessions with the new mothers are held biweekly to improve parenting skills and teach the basics of child development.

Since opening in 1979, the five school-based clinics have served over 7000 students. The program's staff have found that their "intense but caring counseling," combined with appropriate medical attention and follow-up, have had a positive effect on teenage birthrates. Birthrates at Lanier High School have declined from about 65 percent in 1979-80 to about 16 percent in 1985-86. Pregnancy-related dropouts have also fallen. Of 182 mothers followed for one year or more, there were no dropouts, compared to a 50 percent dropout rate for teen mothers before the program began. By meeting students' health and psychological needs, the Jackson-Hinds School-Based Adolescent Health Program increases the chances that at-risk students will reap the full benefits of their education.

For more information, contact:

Maxine Orey, Director of Adolescent Services
Jackson-Hinds School Based Adolescent Health Program
P.O. Box 3437
Jackson, Mississippi 39207
(601)-362-5321

CONCLUSION

From the well-established and extensive Jackson-Hinds School Based program to the more modest effort in Greene County, North Carolina to the fledgling programs in South Carolina and Florida, all have gained respect and support from students, their parents, and the community. All provide much needed medical and social services to student bodies that are disproportionately poor and at-risk, performing poorly in school, and dropping out. All function as the focal point for coordinating a variety of services for adolescents, guiding students through the maze of organizations and procedures that too often has deterred them from seeking help or locating necessary resources.

School-based clinics alone will not solve the problem of inadequate health care or teenage pregnancy. The roots of these problem go back too far and are too complex for a single solution. Nor will they be necessary or appropriate for all communities. However, in many communities throughout the South, school-based clinics could have a significant impact on the health and well-being of teenagers whose options in life have been reduced by poverty, ill health, early pregnancies, or drug and alcohol abuse. By providing technical assistance and funding for school-based clinics, along with support for

other promising state and local efforts that increase the health, educational, and employment options of our at-risk youth, southern states can improve the chances that all their children will grow up healthy and well-educated. The interdependent lives of all Southerners will be the beneficiaries.

NOTES

1. South Carolina Department of Health and Environmental Control, Teenage Pregnancy in South Carolina. Everybody's Problem (October 1983), p. 1.

2. Marian Wright Edelman, "Adolescent Pregnancy: Everybody's Problem," The Journal of State Government (November/December 1986), p. 156.

3. Preventing Adolescent Pregnancy. What Schools Can Do (Washington, D. C.: Children's Defense Fund Adolescent Pregnancy Prevention Clearinghouse, September 1986), p. 4.

4. Edelman, p. 157.

5. Teenage Pregnancy: The Problem That Hasn't Gone Away (New York: The Alan Guttmacher Institute, 1981), p. 30.

6. Martha Burt, Estimates of Public Costs for Teenage Childbearing, Executive Summary (Washington, D.C.; Center for Population Options, September 1986).

7. Building Health Programs for Teenagers (Washington, D. C.: Children's Defense Fund Adolescent Pregnancy Prevention Clearinghouse, May 1986), p. 9.

8. Dr. Murray Vincent and Andrew Clearie, "School/Community Sexual Risk Reduction Program for Teens" (Columbia, South Carolina: Department of Health Promotion and Education, School of Public Health, University of South Carolina).

9. Quoted in Clinic News. (Washington, D.C.: Support Center, Center for Population Options, April 1986), p. 2.

10. Ibid.

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